

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0020925</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>North Adams Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>11/01/02</u> to <u>10/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>Box 100</u> <u>Mendon</u> <u>62351</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Adams</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>217-936-2137</u> <b>Fax #</b> ( ) _____		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>James G. Hull</u> <u>Vice President</u> (Firm Name & Address) <u>WDM Computer Services</u> <u>1900 Harrison, Quincy, IL 62301</u> (Telephone) <u>217-228-1950</u> <b>Fax #</b> <u>217-222-6053</u>	
<b>IDPA ID Number:</b> <u>37-0978651001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>10/16/77</u>			
<b>Type of Ownership:</b>			
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
<b>IRS Exemption Code</b> <u>501 c 3</u>			
<input type="checkbox"/> <b>PROPRIETARY</b>			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>GOVERNMENTAL</b>			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>James G. Hull</u> <b>Telephone Number:</b> <u>217-228-1950</u>			

Facility Name & ID Number North Adams Home# 0020925 Report Period Beginning: 11/01/02 Ending: 10/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,785</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,785</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,427</u>	<u>264</u>	<u>1,377</u>	<u>5,068</u>	8
9	SNF/PED					9
10	ICF	<u>20,375</u>	<u>10,952</u>		<u>31,327</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,802</u>	<u>11,216</u>	<u>1,377</u>	<u>36,395</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 91.48%D. How many bed-hold days during this year were paid by Public Aid?  
\_\_\_\_\_ (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)Adult day Care/Respite CareF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☒ NO ☐I. On what date did you start providing long term care at this location?  
Date started 10/16/77J. Was the facility purchased or leased after January 1, 1978?  
YES ☐ Date \_\_\_\_\_ NO ☒K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number  
of beds certified 7 and days of care provided \_\_\_\_\_Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 10/31/02 Fiscal Year: 10/31/02

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number North Adams Home

# 0020925

Report Period Beginning:

11/01/02

Ending:

10/31/03

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	201,920	9,809	6,111	217,840		217,840	(8,222)	209,618		1
2	Food Purchase		163,272		163,272		163,272	(521)	162,751		2
3	Housekeeping	65,352	18,532		83,884		83,884		83,884		3
4	Laundry	97,011	7,773		104,784		104,784		104,784		4
5	Heat and Other Utilities			97,267	97,267		97,267		97,267		5
6	Maintenance	46,901	11,884	37,984	96,769		96,769		96,769		6
7	Other (specify):*			11,368	11,368		11,368		11,368		7
8	<b>TOTAL General Services</b>	411,184	211,270	152,730	775,184		775,184	(8,743)	766,441		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,380,724	64,063	7,929	1,452,716		1,452,716	(262)	1,452,454		10
10a	Therapy	64,707	615	106,439	171,761	1,095	172,856		172,856		10a
11	Activities	65,756	12,252		78,008		78,008	(258)	77,750		11
12	Social Services	50,947	143	3,520	54,610		54,610		54,610		12
13	Nurse Aide Training			1,502	1,502		1,502		1,502		13
14	Program Transportation	10,138		352	10,490		10,490		10,490		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,572,272	77,073	129,342	1,778,687	1,095	1,779,782	(520)	1,779,262		16
	<b>C. General Administration</b>										
17	Administrative	63,669			63,669		63,669		63,669		17
18	Directors Fees										18
19	Professional Services			84,329	84,329	80	84,409	(75)	84,334		19
20	Dues, Fees, Subscriptions & Promotions			35,186	35,186	(80)	35,106	(26,641)	8,465		20
21	Clerical & General Office Expenses	71,036	38,183		109,219		109,219	(1,529)	107,690		21
22	Employee Benefits & Payroll Taxes			293,195	293,195	(1,095)	292,100	(2,885)	289,215		22
23	Inservice Training & Education			1,203	1,203		1,203		1,203		23
24	Travel and Seminar			8,067	8,067		8,067		8,067		24
25	Other Admin. Staff Transportation			998	998		998		998		25
26	Insurance-Prop.Liab.Malpractice			65,800	65,800		65,800		65,800		26
27	Other (specify):*			647	647		647	(647)			27
28	<b>TOTAL General Administration</b>	134,705	38,183	489,425	662,313	(1,095)	661,218	(31,777)	629,441		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,118,161	326,526	771,497	3,216,184		3,216,184	(41,040)	3,175,144		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number North Adams Home

#0020925

Report Period Beginning:

11/01/02

Ending:

10/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			176,822	176,822		176,822	(476)	176,346			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			123,122	123,122		123,122	(10,367)	112,755			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,092	5,092		5,092		5,092			35
36	Other (specify):*			15,088	15,088		15,088	(14,404)	684			36
37	<b>TOTAL Ownership</b>			320,124	320,124		320,124	(25,247)	294,877			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			4,130	4,130		4,130		4,130			38
39	Ancillary Service Centers		36,447	3,018	39,465		39,465		39,465			39
40	Barber and Beauty Shops		597	16,841	17,438		17,438		17,438			40
41	Coffee and Gift Shops		5,806		5,806		5,806		5,806			41
42	Provider Participation Fee			59,677	59,677		59,677		59,677			42
43	Other (specify):*			371	371		371	(371)				43
44	<b>TOTAL Special Cost Centers</b>		42,850	84,037	126,887		126,887	(371)	126,516			44
	<b>GRAND TOTAL COST</b>											
45	(sum of lines 29, 37 & 44)	2,118,161	369,376	1,175,658	3,663,195		3,663,195	(66,658)	3,596,537			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**VI. ADJUSTMENT DETAIL**      A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	<b>NON-ALLOWABLE EXPENSES</b>				
1	Day Care	\$ (50)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,222)	1		4
5	Telephone, TV & Radio in Resident Rooms	(41)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(172)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(240)	30		9
10	Interest and Other Investment Income	(10,367)	32		10
11	Discounts, Allowances, Rebates & Refunds	(133)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(371)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,918)	36		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(647)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(26,641)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(15,468)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (66,270)		\$	30

<b>OHF USE ONLY</b>						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*	(388)	2	32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (388)		36
	(sum of SUBTOTALS (A) and (B) )			
37	<b>TOTAL ADJUSTMENTS</b>	\$ (66,658)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
 (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

North Adams Home

ID# 0020925

Report Period Beginning: 11/01/02

Ending: 10/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Non-allowable Deprec.	\$ (236)	30	1
2	Activity Program Income	(258)	11	2
3	Badge Replacement	(5)	21	3
4	Loan Fees	(4,453)	36	4
5	Bad Debts	(6,073)	36	5
6	Misc.	40	36	6
7	W/C Refund	(2,885)	22	7
8	Telephone Refund	(1,483)	21	8
9	Nursing Supply Refund	(40)	10	9
10	November Invoice	(75)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(15,468)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number North Adams Home

# 0020925

Report Period Beginning:

11/01/02

Ending:

10/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(8,222)	0	0	0	0	0	0	0	0	0	0	(8,222)	1
2	Food Purchase	(521)	0	0	0	0	0	0	0	0	0	0	(521)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,743)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,743)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(262)	0	0	0	0	0	0	0	0	0	0	(262)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(258)	0	0	0	0	0	0	0	0	0	0	(258)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(520)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(520)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(75)	0	0	0	0	0	0	0	0	0	0	(75)	19
20	Fees, Subscriptions & Promotions	(26,641)	0	0	0	0	0	0	0	0	0	0	(26,641)	20
21	Clerical & General Office Expenses	(1,529)	0	0	0	0	0	0	0	0	0	0	(1,529)	21
22	Employee Benefits & Payroll Taxes	(2,885)	0	0	0	0	0	0	0	0	0	0	(2,885)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(647)	0	0	0	0	0	0	0	0	0	0	(647)	27
28	<b>TOTAL General Administration</b>	<b>(31,777)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(31,777)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(41,040)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(41,040)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number    North Adams Home#    0020925

Report Period Beginning:

11/01/02

Ending:

10/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(476)	0	0	0	0	0	0	0	0	0	0	(476)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,367)	0	0	0	0	0	0	0	0	0	0	(10,367)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(14,404)	0	0	0	0	0	0	0	0	0	0	(14,404)	36
37	<b>TOTAL Ownership</b>	<b>(25,247)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(25,247)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(371)	0	0	0	0	0	0	0	0	0	0	(371)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(371)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(371)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(66,658)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(66,658)</b>	<b>45</b>

Facility Name & ID Number North Adams Home# 0020925

Report Period Beginning:

11/01/02

Ending:

10/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/02 Ending: 10/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number North Adams Home# 0020925 Report Period Beginning: 11/01/02 Ending: 10/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number North Adams Home# 0020925

Report Period Beginning:

11/01/02

Ending:

10/31/03

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	The Manifest Group		X	Equipment Purchase	\$503.25	05/07/01	\$ 14,621	\$ 3,523	06/07/04	14.5000	\$ 1,064	1	
2	Caterpillar		X	Generator	\$454.00	01/11/02	12,723	5,677	1/11/08	7.9000	636	2	
3	First Bankers Trust		X	Mortgage	\$17,461.00	10/23/01	1,466,855	1,220,281	02/23/11	6.2196	82,015	3	
4	North Adams State Bank		X	Cash Flow Payoff	\$3,248.55	03/16/01	250,000	170,844	03/31/04	9.0000	11,908	4	
5												5	
	Working Capital												
6	See Attached List		X	Cash Flow	Interest	See List	960,374	594,303	See List	See List	27,499	6	
7												7	
8												8	
9	TOTAL Facility Related				\$21,666.80		\$ 2,704,573	\$ 1,994,628				\$ 123,122	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$ 2,704,573	\$ 1,994,628				\$ 123,122	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.         </div>			
1. Real Estate Tax accrual used on 2002 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			
<b>TOTAL REFUND \$                      For                      Tax Year.      (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998	8	
	1999	9	
	2000	10	
	2001	11	
	2002	12	

	<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME North Adams Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0020925

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A.

Square Feet:

48,950

B.

General Construction Type:

Exterior

Brick

Frame

Fire Resistant

Number of Stories

1

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable)

North Adams Home, Inc., Medical Clinic, 2567 Sq Ft

North Adams Home, Inc., Cottages, 2756 Sq Ft

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	435,600	1975	\$ 22,893	1
2					2
3	TOTALS	435,600		\$ 22,893	3

Facility Name &amp; ID Number North Adams Home

# 0020925

Report Period Beginning:

11/01/02

Ending:

10/31/03

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	88	1977	1977	\$ 1,036,037	\$ 25,944	40	\$ 25,901	\$ (43)	\$ 672,807
5	1	1978	1978	2,633		10			2,633
6	10	1986	1986	438,224	14,673	30	14,607	(66)	252,367
7	10	1997	1997	1,374,932	34,442	40	34,373	(69)	225,615
8									
<b>Improvement Type**</b>									
9	Garage	1981		26,358					26,245
10	Building Improvement	1979		1,158					1,158
11	Building Improvement	1980		187					187
12	Building Improvement	1981		121					121
13	Building Improvement	1983		2,105					2,105
14	Building Improvement	1985		1,082					1,082
15	Land Improvement	1977		6,339					6,339
16	Land Improvement	1978		3,756					3,756
17	Land Improvement	1979		15,608					15,608
18	Land Improvement	1980		1,556					1,556
19	Land Improvement	1982		337					337
20	Land Improvement	1983		11,703					11,703
21	Land Improvement	1985		2,618					2,618
22	Land Improvement (IDPA)	1986		7,661					7,661
23	Generator	1979		11,412					11,412
24	Intercom System	1980		1,319					1,319
25	Fixed Equipment	1982		29,082					29,082
26	Building Improvement	1986		28,142					28,142
27	Building Improvement	1986		47,328					47,328
28	Building Improvement	1987		9,880					9,824
29	Building Improvement	1987		4,145					4,122
30	Building Improvement	1987		6,319					6,284
31	Building Improvement	1987		3,244					3,225
32	Land Improvement (IDPA)	1986		10,159					10,159
33	Land Improvement (IDPA)	1987		1,192					1,192
34	Land Improvement	1987		1,255					1,255
35	Wall Carpet	1988		12,374	210	15	210		12,304
36	Cabinets/doors	1988		5,316	266	20	266		4,053

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Sprinklers	1988	\$ 663	\$ 27	25	\$ 27	\$	\$ 404	37	
38	Exhaust Fan/Door Locks	1988	2,151	119	15	119		2,139	38	
39	Sidewalk & Shelton Floor	1988	2,583					2,583	39	
40	Land Improvements	1988	3,052					3,052	40	
41	Patient Sensor System	1989	3,964					3,964	41	
42	Dining Room Remodel	1989	3,943	263	15	263		3,746	42	
43	Garage	1990	31,318	1,044	30	1,044		13,658	43	
44	Parking Lot Paving	1990	10,500					10,500	44	
45	Parking Lot Grading	1990	1,017					1,009	45	
46	Roof repairs	1990	1,372	91	15	91		1,181	46	
47	Land Improvements	1993	760	6	10	6		754	47	
48	Roof	1991	82,210	4,128	20	4,111	(17)	51,252	48	
49	Patio	1994	15,076	1,508	10	1,508		13,822	49	
50	Electric Doors	1994	2,867	191	15	191		1,704	50	
51	Storage Room	1995	1,662	111	15	111		941	51	
52	Patient Sensor System	1996	2,340	236	10	234	(2)	1,789	52	
53	Landscaping	1996	776	78	10	78		560	53	
54	Carpet	1996	1,183	79	15	79		575	54	
55	Ventilation	1996	1,154	77	15	77		541	55	
56	Nursing Cabinets	1996	9,378	629	15	625	(4)	4,399	56	
57	New Addition - Garden	1997	25,624	2,586	10	2,562	(24)	17,006	57	
58	New Addition - Egress	1997	4,431	447	10	443	(4)	2,940	58	
59	Laundry Remodel	1997	13,967	936	15	931	(5)	5,695	59	
60	Re-roof	1998	5,232	349	15	349		1,903	60	
61	Alarm System	1999	2,466	164	15	164		740	61	
62	Roof repairs	1999	11,000	733	15	733		3,300	62	
63	Lanscaping	1999	992	99	10	99		413	63	
64	Shower Remodel	1999	2,792	141	20	140	(1)	528	64	
65	Power Door (scu)	2000	1,233	123	10	123		442	65	
66	New Railing	2000	670	67	10	67		234	66	
67	Fire Wall	2000	21,922	1,096	20	1,096		3,562	67	
68	Oxygen Room	2000	2,409	120	20	120		392	68	
69	Dampers	2000	2,581	172	15	172		559	69	
70	TOTAL (lines 4 thru 69)		\$ 3,376,870	\$ 91,155		\$ 90,920	\$ (235)	\$ 1,559,886	70	

\*\*Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar								
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 3,376,870	\$ 91,155		\$ 90,920	\$ (235)	\$ 1,559,886	1
2 Duct Detectors	2000	2,285	228	10	228		743	2
3 Emergency Lighting	2000	2,119	212	10	212		689	3
4 Smoke/Fire Dampers	2000	1,300	130	10	130		412	4
5 Emergency Lighting	2000	801	80	10	80		254	5
6 Roof Recoating	2001	28,450	1,897	15	1,897		4,426	6
7 Carpet for special care unit	2001	1,780	181	10	178	(3)	407	7
8 Concrete to lift room	2001	1,900	95	20	95		215	8
9 Remodel 8 Rooms	2001	11,757	784	15	784		1,633	9
10 Fencing	2001	877	88	10	88		197	10
11 Generator	2002	18,497	925	20	925		1,767	11
12 Wall Panel	2002	1,829	185	10	183	(2)	353	12
13 Activity Room Flooring	2002	4,308	431	10	431		754	13
14 Concrete work	2002	937	47	20	47		78	14
15 Parking Lot Light	2002	788	53	15	53		83	15
16 Room Remodel	2002	9,522	635	15	635		741	16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,464,020	\$ 97,126		\$ 96,886	\$ (240)	\$ 1,572,638	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 675,741	\$ 69,867	\$ 69,868	\$ 1	5-15	\$ 389,068	71
72	Current Year Purchases	13,928	487	487	0	5-10	487	72
73	Fully Depreciated Assets	255,786				5-15	255,064	73
74								74
75	TOTALS	\$ 945,455	\$ 70,354	\$ 70,355	\$ 1		\$ 644,619	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportaion	1980 Ford Van	1990	\$ 45,725	\$	\$		5	\$ 45,725	76
77	Patient Transportaion	Bus	1999	37,900	7,580	7,580		5	30,952	77
78	Patient Transportaion	Chevy Van	2002	7,500	1,525	1,525		5	2,034	78
79										79
80	TOTALS			\$ 91,125	\$ 9,105	\$ 9,105			\$ 78,711	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,523,493	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 176,585	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 176,346	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (239)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,295,968	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottage #1	\$ 75,325	\$ 2,404	\$ 53,085	86
87	Medical Clinic	176,944	5,684	126,265	87
88	Land Trust	49,865			88
89	Beauty & Barber	1,234		1,234	89
90	See Attached List	442,185	12,955	140,649	90
91	TOTALS	\$ 745,553	\$ 21,043	\$ 321,233	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 5,092

Description: See List attached

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2004 \$ \_\_\_\_\_

13. \_\_\_\_\_/2005 \$ \_\_\_\_\_

14. \_\_\_\_\_/2006 \$ \_\_\_\_\_

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input checked="" type="checkbox"/>
		COMMUNITY COLLEGE <input checked="" type="checkbox"/>	HOURS PER AIDE <u>56</u>
		HOURS PER AIDE <u>99</u>	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 1,032	\$	\$ 1,032
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		470		470
9	TOTALS	\$	\$ 1,502	\$	\$ 1,502
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,502		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 69,265	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	357,359		3
4	Supply Inventory (priced at <u>Fifo</u> )	30,499		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,254		6
7	Other Prepaid Expenses	3,175		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Receivables</u>	45,719		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 517,271	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	110,255		12
13	Land	72,758		13
14	Buildings, at Historical Cost	4,114,129		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,039,769		16
17	Accumulated Depreciation (book methods)	(2,588,123)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	20,979		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,769,767	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,287,038	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 180,049	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	594,303		29
30	Accrued Salaries Payable	164,398		30
31	Accrued Taxes Payable (excluding real estate taxes)	441		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,243		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Liabilities</u>	1,223		36
37	<u>Rounding</u>	1		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 942,658	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	180,044		39
40	Mortgage Payable	1,220,281		40
41	Bonds Payable			41
42	Deferred Compensation	205,778		42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,606,103	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,548,761	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 738,277	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,287,038	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 806,692	1
2	Restatements (describe):		2
3	Prior Period Adjustments (Audit not complete until April 03)	(2,251)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 804,441	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(71,778)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Cottages (Net Income)	9,343	15
16	Other (describe) Medical Clinic (Net Income)	(3,729)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (66,164)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 738,277	24 *

\* This must agree with page 17, line 47.

## STATE OF ILLINOIS

Facility Name &amp; ID Number North Adams Home

# 0020925

Report Period Beginning: 11/01/02

Ending:

Page 19

10/31/03

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,283,183	1
2	Discounts and Allowances for all Levels	(26,042)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,257,141	3
<b>B. Ancillary Revenue</b>			
4	Day Care	50	4
5	Other Care for Outpatients		5
6	Therapy	162,356	6
7	Oxygen	3,406	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 165,812	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education	1,487	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	6,111	12
13	Barber and Beauty Care	19,877	13
14	Non-Patient Meals	8,222	14
15	Telephone, Television and Radio	41	15
16	Rental of Facility Space		16
17	Sale of Drugs	31,114	17
18	Sale of Supplies to Non-Patients	172	18
19	Laboratory	370	19
20	Radiology and X-Ray	103	20
21	Other Medical Services	400	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 67,897	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	56,721	24
25	Interest and Other Investment Income***	10,367	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 67,088	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>AccuChecks</b>	1,430	28
28a	<b>See List Attached</b>	32,049	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 33,479	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,591,417	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	775,184	31
32	Health Care	1,778,687	32
33	General Administration	662,313	33
<b>B. Capital Expense</b>			
34	Ownership	320,124	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	67,210	35
36	Provider Participation Fee	59,677	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,663,195	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(71,778)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (71,778)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number North Adams Home# 0020925Report Period Beginning: 11/01/02Ending: 10/31/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,040	2,088	\$ 47,571	\$ 22.78	1
2	Assistant Director of Nursing	2,024	2,126	44,528	20.94	2
3	Registered Nurses	8,914	9,220	169,587	18.39	3
4	Licensed Practical Nurses	31,410	32,884	453,315	13.79	4
5	Nurse Aides & Orderlies	68,966	72,253	645,995	8.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,986	6,416	64,707	10.09	8
9	Activity Director	1,981	2,133	24,602	11.53	9
10	Activity Assistants	5,580	6,021	41,154	6.84	10
11	Social Service Workers	4,046	4,221	50,947	12.07	11
12	Dietician					12
13	Food Service Supervisor	1,979	2,116	23,046	10.89	13
14	Head Cook	1,479	1,584	15,749	9.94	14
15	Cook Helpers/Assistants	12,728	13,311	87,436	6.57	15
16	Dishwashers	11,021	11,504	75,689	6.58	16
17	Maintenance Workers	4,122	4,511	46,901	10.40	17
18	Housekeepers	8,225	8,769	65,352	7.45	18
19	Laundry	9,894	10,609	97,011	9.14	19
20	Administrator	2,056	2,148	46,254	21.53	20
21	Assistant Administrator	870	870	12,917	14.85	21
22	Other Administrative	87	193	4,498	23.31	22
23	Office Manager					23
24	Clerical	6,761	7,602	71,036	9.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,825	1,876	19,728	10.52	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	1,187	1,197	10,138	8.47	33
34	TOTAL (lines 1 - 33)	193,181	203,652	\$ 2,118,161 *	\$ 10.40	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	\$ 6,111	1-3	35
36	Medical Director	Contract	9,600	9-3	36
37	Medical Records Consultant	12	1,200	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,018	39-3	39
40	Physical Therapy Consultant	1,286	53,141	10a-3	40
41	Occupational Therapy Consultant	399	24,870	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	221	18,373	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	88	3,520	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,198	\$ 119,833		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	176	4,878	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	176	\$ 4,878		53

Facility Name & ID Number    **North Adams Home**

**XIX. SUPPORT SCHEDULES**

STATE OF ILLINOIS

#    **0020925**

Page 21

Report Period Beginning:    **11/01/02**    Ending:    **10/31/03**

<b>A. Administrative Salaries</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 20%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td><u>Greg Sandidge</u></td> <td><u>Administrator</u></td> <td style="text-align: center;"><u>0</u></td> <td style="text-align: right;">\$ <u>46,254</u></td> </tr> <tr> <td><u>John Bainum</u></td> <td><u>Administrator</u></td> <td style="text-align: center;"><u>0</u></td> <td style="text-align: right;">\$ <u>4,498</u></td> </tr> <tr> <td><u>Pat Leyendecker</u></td> <td><u>Comptroller</u></td> <td style="text-align: center;"><u>0</u></td> <td style="text-align: right;">\$ <u>12,917</u></td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ <u>63,669</u></td> </tr> </tbody> </table>			Name	Function	Ownership %	Amount	<u>Greg Sandidge</u>	<u>Administrator</u>	<u>0</u>	\$ <u>46,254</u>	<u>John Bainum</u>	<u>Administrator</u>	<u>0</u>	\$ <u>4,498</u>	<u>Pat Leyendecker</u>	<u>Comptroller</u>	<u>0</u>	\$ <u>12,917</u>													TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ <u>63,669</u>	<b>D. 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<u>Illinois Municipal Retirement Fund (IMRF)*</u>																																																																																																		
<u>Life Insurance</u>	\$ <u>6,314</u>																																																																																																	
<u>Physicals</u>	\$ <u>448</u>																																																																																																	
<u>Vacation Accrual Adjustment</u>	\$ <u>280</u>																																																																																																	
<u>401 K Match</u>	\$ <u>10,803</u>																																																																																																	
TOTAL (agree to Schedule V, line 22, col.8)																																																																																																		
Description	Amount																																																																																																	
<u>IDPH License Fee</u>	\$ <u> </u>																																																																																																	
<u>Advertising: Employee Recruitment</u>	\$ <u>857</u>																																																																																																	
<u>Health Care Worker Background Check</u> (Indicate # of checks performed <u>41</u> )	\$ <u>492</u>																																																																																																	
<u>See List Attached</u>	\$ <u>6,607</u>																																																																																																	
<u>Newspaper &amp; Mag. Subscriptions</u>	\$ <u>476</u>																																																																																																	
<u>Trailer License Fee</u>	\$ <u>18</u>																																																																																																	
<u>Public Relation/Advertising</u>	\$ <u>26,641</u>																																																																																																	
<u>Charitable Trust Bureau Fee</u>	\$ <u>15</u>																																																																																																	
<u>Less: Public Relations Expense</u>	\$ <u>(18,621)</u>																																																																																																	
<u>Non-allowable advertising</u> (																																																																																																		
<u>Yellow page advertising</u>	\$ <u>(8,020)</u>																																																																																																	
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<b>B. Administrative - Other</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td><u>n/a</u></td> <td style="text-align: right;">\$ <u>0</u></td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</td> </tr> </tbody> </table>			Description	Amount	<u>n/a</u>	\$ <u>0</u>							TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Description</th> <th style="width: 10%;">Line #</th> <th style="width: 50%;">Amount</th> </tr> </thead> <tbody> <tr> <td><u>n/a</u></td> <td> </td> <td style="text-align: right;">\$ <u>0</u></td> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <td colspan="2">TOTAL</td> <td style="text-align: right;">\$ <u> </u></td> </tr> </tbody> </table>			Description	Line #	Amount	<u>n/a</u>		\$ <u>0</u>																															TOTAL		\$ <u> </u>	<b>G. Schedule of Travel and Seminar**</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td><u>Out-of-State Travel</u></td> <td style="text-align: right;">\$ <u> </u></td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td><u>In-State Travel</u></td> <td> </td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td><u>Seminar Expense</u></td> <td> </td> </tr> <tr> <td><u>See List Attached</u></td> <td style="text-align: right;">\$ <u>8,067</u></td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td><u>Entertainment Expense</u> (</td> <td> </td> </tr> <tr> <td colspan="2">(agree to Sch. V, line 24, col. 8)</td> </tr> <tr> <td>TOTAL</td> <td style="text-align: right;">\$ <u>8,067</u></td> </tr> </tbody> </table>			Description	Amount	<u>Out-of-State Travel</u>	\$ <u> </u>					<u>In-State Travel</u>								<u>Seminar Expense</u>		<u>See List Attached</u>	\$ <u>8,067</u>					<u>Entertainment Expense</u> (		(agree to Sch. V, line 24, col. 8)		TOTAL	\$ <u>8,067</u>									
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\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. See List Attached
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,238 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 59,677  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,222
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 10,422  
c. What percent of all travel expense relates to transportation of nurses and patients? 94.6  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Arnolds, Behrens, Deters & Grey The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

North Adams Home Board of Directors as of 10/31/03.

<u>Name</u>	<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>
Asher, Terry	1431 Hemingway N.	Quincy	IL	62305-9202
Beeler, Russell	320 N Hwy 96	Sutter	IL	62373
Burke, Carroll	1573 Hwy 61	Loraine	IL	62349
Butler, Gary	92 NCR 840	Mendon	IL	62351
Clair, Dan	1451 N. 2800th St.	Loraine	IL	62349
Finlay, Mike	121 E. High St.	Mendon	IL	62351
Frese, Lawrence H.	2149 E 1200th St	Mendon	IL	62351
Hibbert, Ron	PO Box 206	Mendon	IL	62351
Husemann, Ronald	1617 N 1600th Ave	Fowler	IL	62338
Kamprath, Tom	309 Adams	Coatsburg	IL	62325
Mealiff, Richard	1591 N. 2400th Ave	Mendon	IL	62351
Venvertloh, Bernard	1444 N. 1750th Ave	Fowler	IL	62338
Wesbecker, Ann	100 Birch St.	Ursa	IL	62376
Woodruff, Sue	232 N. Chestnut	Mendon	IL	62351

\* Ron Huseman provides some woodworking and carpentry work.

\* Kathy Kircher provides pamphlets.

North Adams Home, Inc. 060925  
11/01/02 thru 10/31/03  
Line 24, Schedule XVII Sec. D

Contributions	
Endowment funds	\$1,460.00
Donated cash	\$48,529.90
Non-cash Donations	\$388.00
Van fund donations	\$236.00
Religious income	<u>\$6,107.00</u>
	<u>\$56,720.90</u>

Line 28a, Schedule XVII Sec. E

Transportation Income	\$14,658.00
Cookbook Revenue	\$1,140.00
Memberships	\$2,251.00
Mini Fair Income	\$7,902.00
Activities Program Income	\$258.00
Personal Purchases Income	\$476.00
Admission Income	\$2,300.00
Badge Replacement Income	\$5.00
Rebates/Refunds & Discounts	\$1,656.00
Loss on Sale of Assets	<u>\$2,122.00</u>
Misc. Income	\$637.00
Workman's Comp. Refund	\$2,885.00
	<u>\$32,149.00</u>

Schedule XIX, Sec. F

Mex Of Illinois	\$1,375.00
Life Services Network Fee	\$4,947.00
Activity Association Dues	\$95.00
UAPAC Membership Dues	\$30.00
Quincy Area Chamber of Commerce Dues	\$160.00
	<u>\$6,607.00</u>

Sch. XX Question #2

a. Life Services Network	\$4,947.00
	<u>\$4,947.00</u>

Line 25, Schedule V

Repairs & Maint. Mini Bus	\$17.07
Repairs & Maint. Bus	\$14.93
Repairs & Maint. Chevy Van	\$22.96
Gas & Oil Mini Bus	\$111.50
Gas & Oil Bus	\$29.41
Gas & Oil Chevy Van	\$62.16
Mini Bus Misc Exp.	\$0.00
Bus Misc Exp.	\$0.00
Chevy Van Misc Exp.	<u>\$1.15</u>
Employee Business Travel	\$741.16
	<u>\$958.03</u>

Line 36, Schedule V

Amortization of refinancing loan fees	\$4,017.00
Loan Origination fees	\$436.20
Misc Exp.	\$644.21
Utilization Fee	\$0.00
Bad Debt	\$6,073.23
Bank & service fees	<u>\$3,917.54</u>
	<u>\$19,088.18</u>

Line 6, Schedule V

Repairs & maint. Dietary	\$2,661.52
Repairs & maint. Laundry	\$1,422.96
Repairs & maint. Bridge	\$9,469.62
Repairs & maint. Equip	\$9,469.10
Repairs & maint. Grounds	\$5,472.75
Repairs & maint. Office	\$1,229.35
Repairs & maint. Computers	\$1,229.95
Repairs & maint. Bridge for Life Safety Code	\$5,100.23
Pest Services	\$1,156.00
Outside services	<u>\$743.50</u>
	<u>\$37,864.98</u>

Line 7, Schedule V

Waste Removal	\$9,791.00
Medical Waste Removal	\$1,576.76
	<u>\$11,367.76</u>

Line 43, Schedule V

Sales Tax	\$371.00
	<u>\$371.00</u>

Line 27, Schedule V

Contributions	\$647.00
	<u>\$647.00</u>

Line 16, Schedule XII

Oxygen Rental	\$4,026.34
Wheelchair Rental	\$207.30
Seat Lift Rental	\$80.00
Power Washer Rental	\$110.00
Postage Meter Rental	<u>\$668.00</u>
	<u>\$5,091.64</u>

Section C, Schedule XIX

Name	Type	Amount
EBC	Fire Administration	\$1,636.00
American Express	Medicare Consulting	\$8,057.00
Dean Woodruff	Legal	\$250.00
North Adams State Bank	Legal	\$120.00
Village of Mendon	Legal	\$400.00
Best Software	Software Support	\$524.00
Qualcomm	Software Support	<u>\$75.00</u>
		<u>\$11,061.00</u>

North Adams Home, Inc. 0020925

11/01/02 thru 10/31/03

Line 90, Schedule XI Sec. F

	<b>Cost</b>	<b>Current Book</b>	<b>Accumulated</b>
Cottage Sewer	839	21	172
Cottage Sewer	24101	604	5481
Cottage Equip	5450	363	3603
Land Imp.	6860	0	0
Land Imp.	6455	0	0
Chapel Equip	11023	95	10310
Cottages	82066	2672	38085
Parking Lot	10300	0	10300
Cottage	127973	4290	46464
Alarm System	1650	110	1183
Appliances	1159	0	1159
Carpet	1320	88	836
Carpet	2110	142	1025
Carpet	1070	73	538
Carpet	1145	77	556
Shelves	500	0	491
Range	660	0	649
Refrigerator	654	131	600
Cottage	137600	3433	14018
Carpet	1388	93	378
Beauty Shop Remodel	846	106	423
Beauty Shop Equip	249	36	136
Refroof Cottage	2486	166	608
Cottage engineering	13316	333	3329
Refrigerator	965	122	305
	<hr/> 442185	<hr/> 12955	<hr/> 140649

North Adams Home, Inc. 0020925  
11/01/02 thru 10/31/03  
Schedule V, Reclassifications

**From**

**To**

Line 22

Line 10a

Reclassification due to therapy expenses being miscoded to fringe benefits.

Line 20

Line 19

Reclassification due to a G/L reclassification being off by \$5.

Line 20

Line 19

Reclassification due to EBC invoice being coded to Dues instead of Prof. Fees

[illegible]

North Adams Home, Inc. 0020925  
11/01/02 thru 10/31/03  
Schedule IX, Working Capital

Name of Lener	Related	Purpose of Loan	Monthly Payment	Date of Note	Original Amt	Balance	Maturity Date	Interest Rate	Reporting Period Interest Exp.
Union Bank	No	Cash Flow	Interest	9/26/2002	\$15,050.00	\$0.00	2/28/2003	12.5000	\$141.09
Union Bank	No	Cash Flow	Interest	4/8/2002	\$330,000.00	\$0.00	2/28/2003	5.2500	\$3,994.84
Union Bank	No	Cash Flow	Interest	12/11/2002	\$75,145.00	\$0.00	2/28/2003	7.5000	\$1,983.68
North Adams State Bank	No	Cash Flow	Interest	4/8/2002	\$10,000.00	\$75,000.00	6/15/2004	8.0000	\$3,875.50
* Union Bank	No	Cash Flow	\$3,372.39	2/24/2003	\$530,179.00	\$519,302.51	2/24/2006	4.5000	\$17,504.17
					<u>\$960,374.00</u>	<u>\$594,302.51</u>			<u>\$27,499.28</u>

\* Loan paid of the other Union Bank cash flow loans.